NATASHA VIRANI, RTC #2378
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Love & Light COUNSELLING

# Intake Form

Name _____ Age _____ Birthdate _____

Address _____ Gender _____ Pronouns _____

City _____ Province _____ Postal code _____

Email _____ Cell Phone:_____

Do you prefer email/text/phone contact? _____

If Client is a Minor, Name of Responsible Adult _____

Address If different from above_____ Phone _____

Name of Emergency Contact _____ Phone _____

Relation to contact _____

*There are times when prior medical and psychological records may be requested.*
*Please make sure that all information given below is correct.*

Do You Have an Addiction?_____If so, please describe _____

Have you ever considered suicide?_____

Are You Now Under a Doctor's Care?_____If yes, Doctor's name: _____

Reason for Doctor's Care: _____

Are You Taking Any Medication?_____If yes, what kind? _____

Reason for Medication: _____

Have you ever been Hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc?

Describe: _____

_____

Any Previous Therapy/Counselling? Y or N

If Yes, Name and Phone Numbers of Counsellors\Therapists:

_____

When and Number of Sessions: _____

Type of Therapy/Counselling: _____

Reason you stopped seeing them? _____

How were you referred to me? _____

*The above information is true and correct to the best of my ability:*

_____ _____
Signed Date
If client is under the age of 18, signature of their parent/guardian.

Name of parent: _____ Relationship to client: _____

Date reviewed and initials: _____